Update on Federal Health Care Reform
December 2012

legal issues and status update

The re-election of the President has reinforced the status of the Affordable Care Act ("ACA"). As expected, several long awaited regulatory proposals were released since Thanksgiving week. These are being reviewed by many across the health care industry as comments are due during the next several weeks. The proposals answer some questions, pose new ones, and leave others unanswered. Representatives of the federal Center for Consumer Information and Insurance Oversight ("CCIIO") held a conference call yesterday for dental plans at which they provided some additional insight on the regulations and the impact on dental benefits. CCIIO is also issuing a Notice of Intent to Provide Dental Coverage in the Exchange. This voluntary reporting data is to be submitted to HHS by December 21.

essential benefits update

The November 20 regulatory proposal included information on Essential Health Benefits ("EHB"). These regulations confirmed that state Children's Health Insurance Program ("CHIP") programs, and the Federal Employees Dental and Vision Plan ("FEDVIP") are the benchmark supplements for pediatric oral health and vision services, and that the default would be FEDVIP for those states that do not select a pediatric benchmark. HHS identified that 17 states have selected CHIP for dental, 1 state chose a minimal dental within a medical benchmark, and the rest chose or were defaulted to FEDVIP. For vision, HHS identified 2 states selecting CHIP, 1 state with minimal vision embedded in medical benchmark, 4 states not disclosed, and the rest selecting or defaulting to FEDVIP. The FEDVIP selections may change as states report benchmark choices to HHS.

HHS also confirmed that adult dental and cosmetic orthodontics would not be considered as EHB, even if they are included in a benchmark, as is the case with the FEDVIP dental plan. HHS recommended that the pediatric age is interpreted as "up to age 19" but that states could name a higher age. At the CCIIO call yesterday, it was confirmed that this pediatric age applies to all pediatric services, not just dental.

The regulations responded to two areas that have been the subject of dental industry advocacy:

Metal Levels – it is proposed that standalone dental plans will not be subject to the same metal levels as medical. High and Low plans are proposed, with actuarial values of 85% and 75% respectively, recognizing deviations of +/- 2%. The Actuarial Value Calculator will not be used for standalone plans; carriers would need to submit their own actuarial certifications with their benefit plans.

Out-of-Pocket Maximums – it is proposed that standalone dental plans will have a separate Annual Limit on Cost Sharing, commonly known as the Out-of-Pocket Maximum ("OOP"). Having a separate OOP will mitigate the need to cross accumulate consumer dental and medical payments. HHS has requested input from the industry as to whether that OOP amount should be set by HHS, the states or plans, and what that amount should be. The National Association of Dental Plans ("NADP") has been considering this issue for some time, and

Milliman consultants have provided analysis on the impact to premiums of various OOP amounts. This has been shared with HHS.

exchanges update

HHS has twice postponed the date that states must submit their decision as to the Exchange model they will pursue. They now have until December 14 to submit their decision and Blueprint for a State Exchange. They have until February 15, 2013 to submit their intent for a State Partnership Exchange. All others will be defaulted to the Federally Facilitated Exchange. As of now only about 17 states have announced they will build a state exchange.

The Federally Facilitated Exchange ("FFE") is expected to initially be a "clearinghouse" model in which all certified Qualified Health Plans ("QHP") and Standalone Dental Plans will be eligible to be offered. Recent regulations also propose that the FFE Small Employer ("SHOP") will be the Employee Choice model, where a qualified employer must allow each employee to select any of the plans in the FFE at the level of coverage selected by the employer.

HHS proposes that the premium subsidies available in the Individual Exchange be allocated in a specific formula that proportions them among the selected QHPs and then any remainder to a standalone dental plan.

The CCIIO representatives also confirmed that their interpretation of the ACA is that when a QHP that excludes pediatric dental is available, the separate offer of the pediatric dental benefit is mandatory, but the purchase is not. HHS intends that there will be reminders to consumers of the importance of the pediatric benefit but they do not believe there is a statutory requirement to purchase it.

The CCIIO representatives noted that states may implement several of the above provisions differently, and we have certainly been seeing this state differentiation. CA is allowing standalone dental and vision policies for supplemental coverage in Individual and SHOP Exchanges, but as of now is requiring medical carriers to provide the pediatric coverage, separately priced. OR and WA are initially requiring medical carriers to provide the pediatric benefits. Ameritas has been involved in NADP and state coalition advocacy efforts in these states. On the other hand, a few states such as CA, CT, MD, MA and NV appear to be allowing standalone vision in Exchanges, though it is not clear if it is to fulfill the pediatric vision benefit and/or to offer supplemental family vision.

HHS also released proposed regulations on the ACA requirement that at least two multi-state plans be offered nationwide in Exchanges. This may occur over time, as the draft application previously released by the Office of Personnel Management ("OPM") stated that carriers must be available in 60% of the states in the first year.

Plan Management details are being worked out by states as well and a new filing platform is being developed by National Association of Insurance Commissioners ("NAIC"). We have participated in state sessions on new policy and rate filing requirements and timetables. System for Electronic Rate and Form Filing ("SERFF") recently announced that their new filing platform will be delayed due to lack of regulatory information from HHS. This will contribute to the already compressed timeframes for plans and states to get policy and rate approvals, with plan certifications occurring in early and mid 2013 in preparation for October enrollments.

Fees of some kind are expected to fund both FFE and state exchanges. It has been reported that Gary Cohen, head of CCIIO, announced that the FFE is considering a fee based on 3.8% of premiums. States are considering various types of fees, including transactional, percentages of premiums, and "sin" taxes.

private market fix update

It was extremely disappointing that none of the recent regulations allow medical plans in the private marketplace to be certified as Qualified Health Plans offering Essential Health Benefit Packages without providing the

essential oral health benefits, even though they are widely available through dental plan issuers. CCIIO representatives confirmed that at this time, in the private marketplace outside Exchanges, Essential Health Benefit Packages for Individuals and Small Businesses can only be offered by carriers offering the full range of essential benefits. Dental plans can offer the benefits, but the purchase would be redundant to what consumers would buy from their medical carriers – although consumer access to the actual dental benefit could be impeded by the high deductible in a medical plan.

CCIIO acknowledged that discussions may still be on going about how to achieve this fix. NADP representatives met with Senator Debbie Stabenow, who has been the champion of the standalone dental issue since 2010. She contacted Secretary Sebelius and is planning another meeting with HHS counsel to discuss the legal authority for HHS to issue regulations clarifying the equitable treatment of standalone dental both inside and outside Exchanges.

Unless fixed, this results in a significant disparity: in the private market, Individuals and non-grandfathered Small Group Employers will have to purchase medical plans that embed robust pediatric dental benefits. In the FFE and potentially many state Exchanges, these same purchasers are not mandated to purchase pediatric dental at all.

In the Affordable Care Act, standalone vision plans are currently treated the same way both in and out of Exchanges, meaning that the pediatric vision benefit is included in the medical carriers' Essential Health Benefit Package offered in the Individual and Small Employer markets. Advocacy continues to promote the ability of standalone vision plans to fulfill the pediatric benefit, and as mentioned above, some states are leading the way on standalone vision offerings.

annual fee on health insurance providers

Although IRS released regulatory proposals last week on the hospital insurance tax (additional Medicare tax), there is still no further guidance from the IRS and the Treasury Department on the ACA provisions related to the Health Insurer fee. However, the U.S. House of Representatives currently has about 221 co-sponsors on a bill (H.R. 1370) to repeal this fee. A grass roots organization "stoptheHIT" has also been formed by the business community to oppose the fee, which is likely to be passed on in the form of higher rates.

It has been understood that dental and vision carriers are included in this assessment as they are not clearly excluded as they are in other sections of the law. NADP has recently written to IRS and the Treasury Department for confirmation of applicability or exception. We hope to have this answer even before regulations are issued.

Self-insured plans and governmental entities are not subject to the fee, and not-for-profit plans may pay reduced amounts or not be subject to the fee depending on their business mix. The amount due will be based on an insurer's net premiums and market share in the industry so that the total collected will reach the amount specified for each year in the ACA. For 2014 the amount identified is $8 billion. It is expected to cost the industry about $87 billion over ten years.

The American Dental Association has announced that it is reviewing recent IRS regulations on the 2.3 tax on medical devices to assess impacts on the dental profession. Any such impacts could result in higher dental charges.

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